General

Guideline Title

Management of chronic pain. A national clinical guideline.

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of chronic pain. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2013 Dec. 64 p. (SIGN publication; no. 136). [196 references]

Guideline Status

This is the current release of the guideline.

Any amendments to the guideline in the interim period will be noted on Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the full-text guideline document.

The grades of recommendations (A–D) and levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Supported Self Management

C - Self management resources should be considered to complement other therapies in the treatment of patients with chronic pain.

Pharmacological Therapies

Non-Opioid Analgesics (Simple and Topical)

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

B - NSAIDs should be considered in the treatment of patients with chronic non-specific low back pain.

B - Cardiovascular and gastrointestinal risk needs to be taken into account when prescribing any NSAID.

Paracetamol

C - Paracetamol (1,000-4,000 mg/day) should be considered alone or in combination with NSAIDs in the management of pain in patients with hip or knee osteoarthritis in addition to non-pharmacological treatments.

Topical NSAIDs

A - Topical NSAIDs should be considered in the treatment of patients with chronic pain from musculoskeletal conditions, particularly in patients who cannot tolerate oral NSAIDs.

Topical Capsaicin

A - Topical capsaicin patches (8%) should be considered in the treatment of patients with peripheral neuropathic pain when first line pharmacological therapies have been ineffective or not tolerated.

Topical Lidocaine

B - Topical lidocaine should be considered for the treatment of patients with postherpetic neuralgia if first line pharmacological therapies have been ineffective.

Topical Rubefacients

B - Topical rubefacients should be considered for the treatment of pain in patients with musculoskeletal conditions if other pharmacological therapies have been ineffective.

Opioids

B - Strong opioids should be considered as an option for pain relief for patients with chronic low back pain or osteoarthritis, and only continued if there is ongoing pain relief. Regular review is required.

B - Patients prescribed opioids should be advised of the likelihood of common side effects such as nausea and constipation.

B - It may be necessary to trial more than one opioid sequentially, as both effectiveness and side effects vary between opioids.

C - Signs of abuse and addiction should be sought at re-assessment of patients using strong opioids. Routine urine drug testing, pill counts or prescription monitoring should not be used to detect problem use.

B - Currently available screening tools should not be relied upon to obtain an accurate prediction of patients at risk of developing problem opioid use before commencing treatment.

D - Specialist referral or advice should be considered if there are concerns about rapid-dose escalation with continued unacceptable pain relief, or if >180 mg/day morphine equivalent dose is required.

Anti-Epilepsy Drugs

Gabapentin

A - Gabapentin (titrated up to at least 1,200 mg daily) should be considered for the treatment of patients with neuropathic pain.

Pregabalin

A - Pregabalin (titrated up to at least 300 mg daily) is recommended for the treatment of patients with neuropathic pain if other first and second line pharmacological treatments have failed.

A - Pregabalin (titrated up to at least 300 mg daily) is recommended for the treatment of patients with fibromyalgia.

B - Flexible dosing may improve tolerability. Failure to respond after an appropriate dose for several weeks should result in trial of a different compound.

Carbamazepine

B - Carbamazepine should be considered for the treatment of patients with neuropathic pain. Potential risks of adverse events should be discussed.

Antidepressants

Tricyclic Antidepressants

A - Tricyclic antidepressants should not be used for the management of pain in patients with chronic low back pain.

A - Amitriptyline (25-125 mg/day) should be considered for the treatment of patients with fibromyalgia and neuropathic pain (excluding human immunodeficiency virus [HIV]-related neuropathic pain).

Serotonin Norepinephrine Re-Uptake Inhibitor

A - Duloxetine (60 mg/day) should be considered for the treatment of patients with diabetic neuropathic pain if other first or second line pharmacological therapies have failed.

A - Duloxetine (60 mg/day) should be considered for the treatment of patients with fibromyalgia or osteoarthritis.

Selective Serotonin Re-Uptake Inhibitor

B - Fluoxetine (20-80 mg/day) should be considered for the treatment of patients with fibromyalgia.

Chronic Pain with Concomitant Depression

B - Optimised antidepressant therapy should be considered for the treatment of patients with chronic pain with moderate depression.

Combination Therapies

A - Combination therapies should be considered for patients with neuropathic pain (a pathway for patients with neuropathic pain can be found in Annex 3 in the original guideline document).

A - In patients with neuropathic pain who do not respond to gabapentinoid (gabapentin/pregabalin) alone, and who are unable to tolerate other combinations, consideration should be given to the addition of an opioid such as morphine or oxycodone. The risks and benefits of opioid use need to be considered.

Psychologically Based Interventions

Multidisciplinary Pain Management Programmes

C - Referral to a pain management programme should be considered for patients with chronic pain.

Unidisciplinary Education

Brief Education

C - Brief education should be given to patients with chronic pain to help patients continue to work.

Behavioural Therapies

Respondent Behavioral Therapies

C - Progressive relaxation or electromyographic (EMG) biofeedback should be considered for the treatment of patients with chronic pain.

Cognitive Behavioural Therapy

C - Cognitive behavioural therapy should be considered for the treatment of patients with chronic pain.

Physical Therapies

Manual Therapy

Low Back Pain

B - Manual therapy should be considered for short term relief of pain for patients with chronic low back pain.

Neck Pain

B - Manual therapy, in combination with exercise, should be considered for the treatment of patients with chronic neck pain.

Exercise

B - Exercise and exercise therapies, regardless of their form, are recommended in the management of patients with chronic pain.

A - Advice to stay active should be given in addition to exercise therapy for patients with chronic low back pain to improve disability in the long term. Advice alone is insufficient.

The following approaches should be used to improve adherence to exercise:

- B - Supervised exercise sessions
- B - Individualised exercises in group settings
- C - Addition of supplementary material
- B - Provision of a combined group and home exercise programme

Electrotherapy

B - Transcutaneous electrical nerve stimulation (TENS) should be considered for the relief of chronic pain. Either low or high frequency TENS can be used.

B - Low level laser therapy should be considered as a treatment option for patients with chronic low back pain.

Complementary Therapies

Acupuncture

A - Acupuncture should be considered for short term relief of pain in patients with chronic low back pain or osteoarthritis.

Definitions:

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

Grades of Recommendation

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A: At least one meta-analysis, systematic review, or randomised controlled trial (RCT) rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Clinical Algorithm(s)

The following algorithms are available from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

- Pathway for chronic pain assessment, early management and care planning in non-specialist settings
- Pathway for patients with neuropathic pain
- Pathway for using strong opioids in patients with chronic pain

Scope

Disease/Condition(s)

Chronic pain

Note: For this guideline, chronic pain is defined as pain that has been present for more than 12 weeks.

Guideline Category

Counseling

Management

Treatment

Clinical Specialty

Endocrinology

Family Practice

Internal Medicine

Pharmacology

Physical Medicine and Rehabilitation

Psychiatry

Psychology

Rheumatology

Intended Users

Advanced Practice Nurses

Nurses

Occupational Therapists

Patients

Pharmacists

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Guideline Objective(s)

To provide recommendations based on current evidence for best practice in the assessment and management of adults with chronic non-malignant pain in non-specialist settings

Note: This guideline does not cover:

> Interventions which are only delivered in secondary care
> Treatment of patients with headache (see SIGN 107, Diagnosis and management of headache in adults)
> Children. While chronic pain occurs in children, some of their treatment options are different to those of adults, and evidence on the paediatric population has not been included in this remit.
> Underlying conditions. Chronic pain is caused by many underlying conditions. The treatment of these conditions is not the focus of this guideline so the search strategies were restricted to the treatment of chronic pain, not specific conditions.

Target Population

Adults with chronic non-malignant pain

Interventions and Practices Considered

1. Self management (directing patients to self help resources)
2. Pharmacological management:
    - Non-steroidal anti-inflammatory drugs (NSAIDs) (oral and topical)
    - Opioids
    - Anti-epilepsy drugs

    - Antidepressants
    - Combination therapies
3. Psychologically based interventions:
    - Multidisciplinary pain management programs
    - Undisciplinary education
    - Behavioural therapies
    - Cognitive behavioural therapy
4. Physical therapies:
    - Manual therapy
    - Exercise
    - Electrotherapy
5. Acupuncture

Major Outcomes Considered

- Reduction in anxiety and pain levels
- Pain scores (30% reduction and 50% reduction)
- Functional ability
- Quality of life (mood, sleep)
- Adverse events/drug reactions
- Return to work rates
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Literature Review

The evidence base for this guideline was synthesised in accordance with Scottish Intercollegiate Guidelines Network (SIGN) methodology. A systematic review of the literature was carried out using an explicit search strategy devised by a SIGN Evidence and Information Scientist. Databases searched include MEDLINE, EMBASE, CINAHL, PsycINFO and the Cochrane Library. The year range covered was 2007 to 2012. Internet searches were carried out on various websites including the US National Guideline Clearinghouse. The main searches were supplemented by material identified by individual members of the development group. Each of the selected papers was evaluated by two members of the group using standard SIGN methodological checklists before conclusions were considered as evidence.

Literature Search for Patient Issues

At the start of the guideline development process, a SIGN Evidence and Information Scientist conducted a literature search for qualitative and quantitative studies that addressed patient issues of relevance to management of patients with chronic pain. Databases searched include MEDLINE, EMBASE, CINAHL and PsycINFO, and the results were summarised and presented to the guideline development group.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. The result of this assessment will affect the level of evidence allocated to the paper, which will in turn influence the grade of recommendation that it supports.

The methodological assessment is based on a number of key questions that focus on those aspects of the study design that research has shown to have a significant influence on the validity of the results reported and conclusions drawn. These key questions differ between study types, and a range of checklists is used to bring a degree of consistency to the assessment process. Scottish Intercollegiate Guidelines Network (SIGN) has based its assessments on the MERGE (Method for Evaluating Research and Guideline Evidence) checklists developed by the New South Wales Department of Health, which have been subjected to wide consultation and evaluation. These checklists were subjected to detailed evaluation and adaptation to meet SIGN's requirements for a balance between methodological rigour and practicality of use.

The assessment process inevitably involves a degree of subjective judgement. The extent to which a study meets a particular criterion - e.g., an acceptable level of loss to follow up - and, more importantly, the likely impact of this on the reported results from the study will depend on the clinical context. To minimise any potential bias resulting from this, each study must be evaluated independently by at least two group members. Any differences in assessment should then be discussed by the full group. Where differences cannot be resolved, an independent reviewer or an experienced member of SIGN Executive staff will arbitrate to reach an agreed quality assessment

Evidence Tables

Evidence tables are compiled by SIGN executive staff based on the quality assessments of individual studies provided by guideline development group members. The tables summarise all the validated studies identified from the systematic literature review relating to each key question. They are presented in a standard format to make it easier to compare results across studies, and will present separately the evidence for each outcome measure used in the published studies. These evidence tables form an essential part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

Additional details can be found in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]), available from the SIGN Web site .

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Synthesising the Evidence

Guideline recommendations are graded to differentiate between those based on strong evidence and those based on weak evidence. This judgement is made on the basis of an (objective) assessment of the design and quality of each study and a (perhaps more subjective) judgement on the consistency, clinical relevance and external validity of the whole body of evidence. The aim is to produce a recommendation that is evidence-based, but which is relevant to the way in which health care is delivered in Scotland and is therefore implementable.

It is important to emphasise that the grading does not relate to the importance of the recommendation, but to the strength of the supporting evidence and, in particular, to the predictive power of the study designs from which that data was obtained. Thus, the grading assigned to a recommendation indicates to users the likelihood that, if that recommendation is implemented, the predicted outcome will be achieved.

Considered Judgement

It is rare for the evidence to show clearly and unambiguously what course of action should be recommended for any given question. Consequently, it is not always clear to those who were not involved in the decision making process how guideline developers were able to arrive at their recommendations, given the evidence they had to base them on. In order to address this problem, Scottish Intercollegiate Guidelines Network (SIGN) has introduced the concept of considered judgement.

Under the heading of considered judgement, guideline development groups summarise their view of the total body of evidence covered by each evidence table.

Each guideline group considers the following factors:

- Quantity, quality, and consistency of evidence
- External validity (generalisability) of studies
- Directness of application to the target population for the guideline
- Any evidence of potential harms associated with implementation of a recommendation
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources needed to treat them in accordance with the recommendation)
- Whether, and to what extent, any equality groups may be particularly advantaged or disadvantaged by the recommendations made
- Implementability (i.e., how practical it would be for the National Health Service [NHS] Scotland to implement the recommendation.)

Then the group is asked to summarise its view on all of these issues, both the quality of the evidence and its potential impact, before making a graded recommendation. This summary should be succinct, and taken together with its views of the level of evidence represent the first draft of the text that will appear in the guideline immediately before a graded recommendation.

Additional detail about SIGN's process for formulating guideline recommendations is provided in Section 7 of the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN Web site .

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation

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A: At least one meta-analysis, systematic review, or randomised controlled trial (RCT) rated as 1++ and directly applicable to the target population; *or*

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; *or*

Extrapolated evidence from studies rated as 2+

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The national open meeting is the main consultative phase of Scottish Intercollegiate Guidelines Network (SIGN) guideline development.

Peer Review

All SIGN guidelines are reviewed in draft form by independent expert referees, who are asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline. A number of general practitioners (GPs) and other primary care practitioners also provide comments on the guideline from the primary care perspective, concentrating particularly on the clarity of the recommendations and their assessment of the usefulness of the guideline as a working tool for the primary care team. The draft is also sent to at least two lay reviewers in order to obtain comments from the patient's perspective.

It should be noted that all reviewers are invited to comment as individuals, not as representatives of any particular organisation or group. Corporate interests, whether commercial, professional, or societal have an opportunity to make representations at the national meeting stage where they can send representatives to the meeting or provide comment on the draft produced for that meeting. Peer reviewers are asked to complete a declaration of interests form.

The comments received from peer reviewers and others are carefully tabulated and discussed with the Chair and with the guideline development group. Each point must be addressed and any changes to the guideline as a result noted or, if no change is made, the reasons for this recorded.

As a final quality control check prior to publication, the guideline and the summary of peer reviewers' comments are reviewed by the SIGN Editorial Group for that guideline to ensure that each point has been addressed adequately and that any risk of bias in the guideline development process as a whole has been minimised. Each member of the guideline development group is then asked formally to approve the final guideline for publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of adults with chronic pain

Potential Harms

Adverse Drug Reactions

- Opioids: somnolence, gastrointestinal effects (constipation, nausea, dyspepsia), headache, fatigue, lethargy, somnolence, and urinary complications (retention hesitancy, disturbance). Serious side effects can include sedation and respiratory depression. Refer to "Side Effects" and "Opioid Misuse" in Section 5.3 in the original guideline document for further information.
- Gabapentin: dizziness, somnolence, peripheral oedema, and gait disturbance
- Non-steroidal anti-inflammatory drugs (NSAIDs): abdominal pain, diarrhoea, oedema, dry mouth, rash, dizziness, headache, and tiredness
- Pregabalin: dizziness, somnolence
- Carbamazepine: rashes
- Amitriptyline: excessive drowsiness
- Topical lidocaine plasters: skin reddening and irritation

Qualifying Statements

Qualifying Statements

- This guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is, however, advised that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.
- Recommendations within this guideline are based on the best clinical evidence. Some recommendations may be for medicines prescribed outwith the marketing authorisation (MA) also known as product license. This is known as 'off label' use.
  Medicines may be prescribed off label in the following circumstances:

  - For an indication not specified within the marketing authorisation
  - For administration via a different route
  - Or administration of a different dose
  - For a different patient population

  An unlicensed medicine is a medicine which does not have MA for medicinal use in humans.

  Generally the off label use of medicines becomes necessary if the clinical need cannot be met by licensed medicines within the marketing authorisation. Such use should be supported by appropriate evidence and experience.

  "Prescribing medicines outside the conditions of their marketing authorisation alters (and probably increases) the prescribers' professional responsibility and potential liability".

  The General Medical Council (GMC) recommends that when prescribing a medicine off label, doctors should:

  - Be satisfied that such use would better serve the patient's needs than an authorised alternative (if one exists).
  - Be satisfied that there is sufficient evidence/experience of using the medicines to show its safety and efficacy, seeking the necessary information from appropriate sources.

- Record in the patient's clinical notes the medicine prescribed and, when not following common practice, the reasons for the choice.
- Take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring the effects of the medicine.

Non-medical prescribers should ensure that they are familiar with the legislative framework and their own professional prescribing standards.

Prior to any prescribing, the licensing status of a medication should be checked in the summary of product characteristics (SPC). The prescriber must be competent, operate within the professional code of ethics of their statutory bodies and the prescribing practices of their employers.

Implementation of the Guideline

Description of Implementation Strategy

Description of Implementation Strategy

Implementation of national clinical guidelines is the responsibility of each National Health Service (NHS) Board and is an essential part of clinical governance. Mechanisms should be in place to review care provided against the guideline recommendations. The reasons for any differences should be assessed and addressed where appropriate. Local arrangements should then be made to implement the national guideline in individual hospitals, units and practices.

Implementation of this guideline will be encouraged by Scottish Intercollegiate Guidelines Network (SIGN) and actively supported by the Chronic Pain Service Improvement Groups. The Scottish Government is supporting NHS boards to establish local Service Improvement Groups in a two year development programme that aims to implement the Scottish service model for chronic pain across Scotland (see Annex 5 in the original guideline document).

Refer to Section 11 in the original guideline document for advice on the resource implications associated with implementing the key clinical recommendations and advice on audit as a tool to aid implementation.

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

Mobile Device Resources

Patient Resources

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of chronic pain. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2013 Dec. 64 p. (SIGN publication; no. 136). [196 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Dec

Guideline Developer(s)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

Source(s) of Funding

Scottish Executive Health Department

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group Members: Dr Lesley Colvin (*Chair*), Consultant in Pain Medicine, Western General Hospital, Edinburgh; Dr Rachel Atherton, Clinical Psychologist, Chronic Pain Management Service, NHS Highland; Dr Jonathan Bannister, Consultant in Anaesthesia and Pain Medicine, Ninewells Hospital, Dundee; Ms Janette Barrie, Nurse Consultant for Long Term Conditions, NHS Lanarkshire; Dr Heather Cameron, Physiotherapy Professional Lead, Western Infirmary, Glasgow; Mr Paul Cameron, Clinical Lead Pain Specialist Physiotherapist, NHS Fife Integrated Pain Management Service; Dr Alan Carson, Consultant Neuropsychiatrist, Royal Edinburgh Hospital; Dr Martin Dunbar, Consultant Clinical Psychologist, The Pain Management Team, Glasgow; Dr Steve Gilbert, Consultant in Anaesthesia and Pain Medicine, Queen Margaret Hospital, Dunfermline; Dr John Hardman, General Practitioner, Dalhousie Medical Practice, Bonnyrigg; Ms Melanie Hutchison, Advanced Occupational Therapist, NHS Fife Integrated Pain Management Service; Mr Malcolm Joss, Specialist Occupational Therapist, Occupational Health and Safety Advisory Services, Rosyth; Professor Arduino Mangoni, Professor of Clinical Pharmacology, Flinders University, Australia; Mr Peter McCarron, Patient representative, Kelty; Mr Ronald Parsons, Patient representative, Leven; Miss Deborah Paton, Lead Pharmacist, Pain Management, Lynebank Hospital, Dunfermline; Ms Kathleen Powderly, Member of the British Acupuncture Council and Member of the Register of Chinese Herbal Medicine, Aberdeen; Professor Stuart Ralston, Professor of Rheumatology, Western General Hospital, Edinburgh; Dr Mick Serpell, Consultant in Pain Medicine, Gartnavel General Hospital, Glasgow; Professor Blair H Smith, Professor of Population Science, University of Dundee; Mrs Lynne Smith, Evidence and Information Scientist, SIGN; Ms Ailsa Stein, Programme Manager, SIGN; Dr John Wilson, Consultant in Anaesthesia and Pain Medicine, Royal Infirmary of Edinburgh

Financial Disclosures/Conflicts of Interest

Declarations of interests were made by all members of the guideline development group. Further details are available from the Scottish Intercollegiate Guidelines Network (SIGN) Executive.

Guideline Status

This is the current release of the guideline.

Any amendments to the guideline in the interim period will be noted on Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Guideline Availability

Electronic copies: Available from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Availability of Companion Documents

The following are available:

- Quick reference guide: Management of chronic pain. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2013 Dec. 2 p. Electronic copies: Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .
- SIGN 50: A guideline developer's handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2011 Sep. 111 p. (SIGN publication; no. 50). Available from the SIGN Web site .

In addition, Section 11 of the original guideline document contains key points to audit.

Executive summaries of SIGN guidelines are available for mobile devices through the guidelines app on the SIGN Web site .

Patient Resources

The following is available:

- Managing chronic pain. A booklet for patients and carers. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2013 Dec. 30 p. Electronic copies: Available in Portable Document Format (PDF) from the SIGN Web site . Also available in large print from the SIGN Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This summary was completed by ECRI Institute on February 6, 2014. The information was verified by the guideline developer on February 10, 2014. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

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Readers with questions regarding guideline content are directed to contact the guideline developer.